James W. Seyfried, DDS
1624 Library Lane
Minden, NV 89423
(775) 782-8176

Get Acquainted Form

Patient's Name: ______________________ Male Female Birthday: __________

Mailing Address: ____

SSN: ______________________ Phone Number: ______________________

Employer: ______________________ Occupation: ______________________

Cell Phone: ______________________ Work Phone: ______________________

Full Name of Spouse, if applicable: ______________________ Email: ______________________

Who may we thank for referring you? ______________________________________

Person to contact in case of emergency: ______________________ Phone: ( ) ______________

Responsible Party Information

Responsible Party Name: ______________________ Relation to Patient ______________________

Address ____

How long at this address? _____ If less than 3 years, previous address ______________________

Social Security Number ______________ ______________________

Employer: ______________________ Occupation: ______________ Birthday: __________

Phone Number: ______________ Work Phone: ______________ Cell Phone: ______________

Dental Insurance? No Yes

Insurance Company Name: ______________________ Address: ______________________

Subscriber's Name: ______________________ ______________________

Birthday: ______________

SSN or ID Number: ______________ Group Number: __________ Plan/Local Number: ______________

Dual Insurance? No Yes (If yes, Please complete the following information)

#2 Insurance Company Name: ______________________ Subscriber's Name: ______________________

Address: ____ Birthday: __________

SSN or ID Number: ______________ Group Number: ______________ Plan/Local Number: __________

Consent

The undersigned hereby authorizes Doctor to take radiographs, study models, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with this patient, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment (for dental services provided in this office for myself or my dependents) is mine, and is due and payable at the time services are rendered, unless previous arrangements have been made. I the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice. I hereby authorize necessary credit information to be obtained by your office.

______________________________ ______________

Signature (Patient/Responsible Party) Date

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THANK YOU FOR YOUR COOPERATION IN SUPPLYLING THE ABOVE INFORMATION

Medical Information

Name of Physician: ______________________ City: ____________ Phone: __________

Date of last medical exam: ____________________ Are you pregnant? No ☐ Yes ☐ Due: __________

Do you have current medical problems? No ☐ Yes ☐ If yes, please state: ________________________

Have you ever had or do you have any of the following? (Please circle any that apply)

Hepatitis
Liver Disease
Jaundice
Rheumatic Fever
Diabetes
High Blood Pressure
Heart Problems, type: __________
Heart Murmur
Shortness of Breath
Stroke, when: __________
Blood Trouble/Anemia/Leukemia
Allergy/Hay Fever
Sinus
OTHER: ________________________

Lung Trouble/Asthma/ TB/ Emphysema
Arthritis
Fainting spells/ Epilepsy/ Convulsions/ Dizziness
Nervous Breakdown
X-ray/ Indium or Cobalt treatment
Tumor or Cancer, type: ____________
Prosthetic Joint Replacement
HIV Infection
Autoimmune Disease
Kidney Disease
Head Injury
Glaucoma
Bone loss and taking Bisphosphonate Drugs

Are you now taking medicines for: (please specify medication)

Pain ____________
Nerves ____________
Sleeping ____________
Blood (thinners, other) ____________
Stomach ____________
Thyroid ____________

Heart ____________
Headaches ____________
Arthritis ____________
Allergy ____________
Birth Control ____________
OTHER: ____________

Have you ever shown an allergy to, been sick from, or been told not to take:

Antibiotics: ____________
Narcotics: ____________
Aspirin

Anesthetic: ____________
Other medications: ____________
Latex Allergy

Have you been told you need to PREMEDICATE before dental appointments by a doctor? _____

Do you have any disease, condition, or problem that is not mentioned above? ____________

Dental History

Reason for this visit ________________________________

Previous Dentist: ____________________ Date last treated: ____________

Date of Last dental x-rays ____________________

Have you ever had orthodontic treatment?	Yes ☐ No ☐
Have you ever had dental extractions?	Yes ☐ No ☐
Have you ever had periodontal (gum) surgery?	Yes ☐ No ☐
Have you noticed any loosening of your teeth?	Yes ☐ No ☐
Do your gums bleed often when you brush your teeth?	Yes ☐ No ☐
Have you ever experienced clicking of the jaw or pain in the joint?	Yes ☐ No ☐
Do you clench or grind your teeth while asleep or awake?	Yes ☐ No ☐
Do you have fear or anxiety related to dental treatment?	Yes ☐ No ☐
Are you unhappy with the appearance of your teeth?	Yes ☐ No ☐

I, the undersigned, have given the above information, have reviewed it and find it accurate. If there are any later changes, I will so inform this practice.

________________________ Signature

____________ Date

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